

Independent Review Board

STATE OF WISCONSIN

MINUTES OF THE MEETING OF JANUARY 17, 2003

Attendance

Board Members: Chair Dr. Jay Gold; Vice-Chair Dr. Paul Millea; Eileen Mallow; Jerry Popowski; and Dr. David Zimmerman.

BHI Staff: John Chapin, Director; Sandra Mahkorn, M.D.; Martha Davis, Chief, Workforce and Provider Survey Section; Judith Nugent, Chief, Person-Level Data and Analysis Section; Richard Miller; and Wen-Jan Tuan.

Others Present: Barbara Rudolph, Center for Health Systems Research and Analysis; and Cindy Helstad, Wisconsin Medical Society.

Call to Order

Dr. Gold called the meeting to order at 10:00 a.m. A quorum was deemed present.

Minutes of the November 22, 2002 meeting

Dr. Gold referred Board members to the minutes of the November 22, 2002 meeting. There were no comments or questions. Dr. Zimmerman moved to approve the minutes, and the motion was seconded. Board members voted unanimously for approval.

Dr. Gold referred Board members to a Washington Post article on risk adjustment of Medicare data for surgery. Although the article does not discuss physician office data, it may be of interest to people because it addresses why it is important to risk-adjust correctly.

Physician Office Visit (POV) data collection project update

Ms. Nugent provided a summary of the record count to date from the current group of data submitters. To date, BHI has over 8 million records. The two issues that BHI has had to deal with internally are that Aurora Health Care submitted over 468,000 records with the wrong quarter identified on them. Now, BHI has to develop business rules for dealing with this type of error. Currently, business rules state that changes to the data submitted through this data collection effort can only be done by the data submitter, not by BHI staff. If they do have to be done by BHI staff, an audit trail needs to be set up that carefully documents any changes made. This is necessary so that no one could say that changes were made arbitrarily.

Training for Phase 2 groups of data submitters was conducted last week and will also be conducted next week. The training has gone very well.

POV Data Quality Report update

Mr. Miller distributed a draft of the Physician Office Visit Data Quality and Completeness Report for IRB members to review. This draft report will also be shared with the Board on Health Care Information, staff from the University of Wisconsin Medical College, Wisconsin Manufacturers and

Commerce, the Wisconsin Health and Hospital Association, the Wisconsin Medical Society, etc. for comment. After that, the draft will go through Department review. It is expected that the publication will be final sometime this spring. The draft was prepared with preliminary data that has not been affirmed by the data submitters. Board members were cautioned that numbers in this draft should be seen as uncorrected and unaffirmed, nonreleasable test data.

Completeness issues were identified. Some data submitting organizations are phasing in their submission because of organizational mergers and system changes. The organizations that are submitting are phasing in also. So, this is only a dozen out of what may be hundreds of practice groups in the state. The quality of the data in terms of required items is pretty good. Submitters have shown progress in reducing systematic problems.

The report will be in draft stage until at least the end of February. Mr. Miller encouraged Board members to contact him with any comments.

Dr. Zimmerman asked if any issues have been identified that may affect policy decisions. Ms. Nugent stated that BHI is aware there are a lot of differences in the various submitting groups and coding. BHI expects that over time, coding will get better.

Dr. Gold asked Mr. Miller if the kinds of defects that BHI has identified in the quality of the data so far are things that one could expect to rectify themselves over time or are the defects something to be concerned about. Mr. Miller suggested the IRB should be concerned because it is not definitely known that they will be rectified over time or how quickly, and that could create some tough-to-detect biases. Mr. Miller stated that some organizations will be alert to the new uses of the data and will make some investments in their systems to make it better information, some may not be so alert or just may not be able to allocate resources. Dr. Gold asked that since we will not have a complete and accurate dataset, how should we be thinking about that in terms of the Independent Review Board's charge. Mr. Miller suggested that BHI should collect as much information as it can about the idiosyncrasies to include in the data users' manual. BHI will need to be sensitive to what types of analyses and for what purposes the data will be used.

Dr. Zimmerman stated that right now we are not collecting a large number of diagnosis codes. This is consistent across the various organizations submitting data. The Independent Review Board will decide in the next several months if it is going to take an aggressive approach to risk adjustment. That is, the IRB would be more likely than less likely to have something risk-adjusted, have an outcome and have the data risk-adjusted for a given request. The number of diagnoses that are available in the database will have a large impact on the extent to which the data can be risk-adjusted since many times risk adjustment is done through comorbidities which come from diagnoses. Providers may realize and anticipate that the IRB will take this aggressive approach and start bringing on as a matter of course more and more diagnoses, but it may not be done uniformly across all providers, and that will create systematic differences. This will make the data look different for some providers than for others and it wouldn't be necessarily a matter of whether or not the comorbidity existed, it would also be a matter of whether or not they would be more likely to report if it existed. This creates a potential issue. Would this be an IRB issue or would this be an issue for the administrative agency that is handling this?

Dr. Gold referred to the Washington Post article, which stated that when the New York State Department of Health decided to implement risk-adjusted report cards to evaluate the quality of cardiovascular care, officials noticed that doctors suddenly started reporting more risk factors. At one hospital, the reported prevalence of chronic obstructive pulmonary disease increased from 1.8 percent to 52.9 percent, while at another hospital the diagnosis of unstable angina went from 1.9 percent to 20.8 percent. Dr. Millea stated that this is already going on now in order to bill at the level of service.

Mr. Chapin re-addressed the issue of responsibility. He suggested the IRB keep in mind the purpose of all this information independent of what is in the statute or the administrative code. What is the public policy mission and purpose of this information? A broad discussion should be held in the next

six months to a year regarding what is really the mission and purpose of this data. Mr. Chapin also reminded members that there has been a political change and there could be a philosophical change.

Dr. Mahkorn commented that the Washington Post article is extremely on point and reminds us that one has to be careful when interpreting data. The mortality probably didn't really change, people were just reporting the risk factors. Dr. Gold stated that it is always important to keep the unintended consequences in mind when interpreting data. Dr. Millea said that it is not always unintended consequences. They could be intended consequences such as physicians not operating on sicker patients. Physicians now offer sicker patients palliative treatment rather than aggressive treatment because it saves money. Americans are consuming much more health care than we want to afford. Dr. Zimmerman said we have to be careful about what the data in the article mean. Either the data were missing a legitimate diagnosis previously or the organizations are now up-coding in 49 percent of the cases, or some combination of the two. Dr. Zimmerman suggested that a gold standard definition be provided which would be very restrictive of whether something could be called chronic obstructive pulmonary disease or not.

Outline strategy for case mix and severity adjustment, presentation of data, and any additional information that accompanies the data

Dr. Zimmerman stated that he does not have a proposal for the strategy but would rather launch a discussion, which possibly provides a framework for how a strategy could be developed. He stated that this issue has been addressed in some detail in a report that was done by staff members at the Center for Health Systems Research and Analysis (CHSRA) specifically related to data adjustment for the physician data system. Copies of CHSRA's report were distributed. Dr. Zimmerman explained that it is his understanding that the CHSRA report was submitted to the Bureau of Health Information and that it was released as a report to the Bureau's Board, etc. and so he feels there is no problem with distributing it. Ms. Rudolph stated that was the case. Mr. Chapin clarified that this was not promulgated as a Department document nor endorsed by the Department as the official final Department view. Mr. Chapin stated that there was a committee, there was a document that was shared internally and shared with the Board, but no one should view this document as an official Department final report or to conclude that the findings in this report are endorsed by the Department. Dr. Zimmerman pointed out that the cover sheet of the report does indicate that it was prepared by CHSRA and submitted to the Bureau of Health Information. Dr. Zimmerman suggested that this is an introduction to a topic that the IRB needs to deal with carefully over the course of the next several meetings and not take any positions at this point.

Dr. Zimmerman suggested the IRB needs to address two questions as they might relate to any given request. The first question is "When a data request comes in, should the data be risk-adjusted?" If there is to be risk adjustment, what types of factors ought to be included in the set that would comprise the risk adjustment? The second question is "If the answer is that it should be risk-adjusted, then what is the appropriate technique that should be used to adjust for risk?" Once you have those two questions answered, other issues are raised that are as important as the answer to those two questions. Another issue that arises quickly is "What should be presented or how should the dataset be presented to the requester?" For example, if it has been decided that something should be risk-adjusted, and the appropriate method is established and implemented, should the requester get the adjusted data, a derivative file not the raw data, or should the requester receive both the adjusted data and the unadjusted data? Receiving both adjusted and unadjusted data would allow the requester to continue to do its own work on the issue of adjustment. Then, there are derivative questions that arise from there. If one permits the requester to have both the adjusted and unadjusted data, is there some restriction that would be placed on the dissemination of that information? This may result in a very detailed set of instructions to the data requester. If the requester is also provided the documentation, they would be able to reverse engineer the adjusted data in order to get unadjusted data anyway.

The issue of whether data is risk-adjusted and what the factors ought to be is a question that needs to

be dealt with. Dr. Zimmerman stated that with physician office data there may not be as much of an issue as has been found in the long-term care area. The point stressed by Dr. Zimmerman is that if the IRB establishes principles and then apply the principles in any given situation, the IRB will be more correct and on stronger defensible grounds when some of the decisions may be challenged.

Dr. Millea expressed his concern that linking physician outcomes to specific physicians is going to shift practice patterns radically, whether it is risk-adjusted or not. The unadjusted data will be affected the most. Basically, physicians will be put at risk of not making the scorecard so physicians will try to shed that risk by referring patients elsewhere. If physicians are given a chance to mitigate their risk through risk adjustment, then you diminish that impact somewhat. Dr. Millea agreed that the Washington Post article is right on track. The consequence will be less health care because the high-risk patients will be pushed towards institutions of last resort, of which there are going to be very few, and there will be less access to care.

Dr. Zimmerman stated that Dr. Millea's points are valid. If the IRB does not look at the potential difference in the likely outcome for a given severity group as opposed to another group, major mistakes in analyses could occur.

Dr. Gold commented that the IRB is a creature of the legislation and that whatever authority the IRB has and whatever boundaries the IRB has are set by the legislation and there is no authority to go beyond that. However, the legislation says that the IRB has to approve all the releases. Therefore, the IRB has the authority to decide what criteria have to be met and the job is to determine what those criteria are.

Mr. Popowski asked what the next step should be. Dr. Zimmerman suggested that the IRB should establish some policies and procedures on how we would address each of the above-stated questions. This would be a contingent model, which is purpose driven. But a procedure needs to be established that the IRB can use that would govern the way in which we deal with the issues so that they can be dealt with on a consistent basis. Experts should be consulted during this process.

Dr. Gold stated that it is important for the IRB to keep in mind what the author of the amendment dealing with data adjustment intended. Mr. Chapin informed members that the Board on Health Care Information is very interested in the IRB, as a charge, looking at this process. Mr. Chapin also suggested that Dr. Zimmerman run some of the datasets under different scenarios of the policies and procedures as an experimental trial. Then, when presenting your recommendation to the Board on Health Care Information, the IRB will have an empirical basis. Mr. Popowski asked if the IRB should make a recommendation to the Board on Health Care Information for their approval. Mr. Chapin stated that communication to the Board is needed because of their referral to the IRB, the Board does not need to approve it. Dr. Gold asked for clarification of what the Board on Health Care Information is requesting of the IRB and stated that the IRB should formally accept that request. Mr. Chapin stated that the Board on Health Care Information referred the question of how should the state go about the business of risk adjustment to the IRB for a recommendation in a policy sense. Dr. Gold commented that for housekeeping purposes the IRB should formally accept that request. Dr. Zimmerman agreed with Dr. Gold that the first responsibility of the IRB is to provide information back to the Board on Health Care Information on risk adjustment strategies. The IRB should, in an organized way, deliberate and make decisions about individual requests and should, to the extent possible, contribute something to the Board on Health Care Information. Mr. Chapin suggested there should be communication back to the Board on Health Care Information.

Dr. Gold suggested that it would be appropriate for the IRB to enact a motion that it is in agreement with the Board on Health Care Information that it is within the purview of the IRB to deal with the issue of developing risk adjustment strategy for the physician office visit data. Mr. Popowski moved to approve the motion, and the motion was seconded. Board members unanimously approved.

Dr. Zimmerman endorsed Mr. Chapin's suggestion for performing a sensitivity analysis of what is the outcome of various approaches to risk adjustment decisions and strategy. In addition to the sensitivity test, Dr. Zimmerman suggested pilot testing the application of whatever set of procedures

and general criteria the IRB establishes with a real example of that process and those criteria to see the result. Where will that help come from and how will the IRB pay for it?

Mr. Chapin informed the IRB that there would be a huge resource barrier that will prohibit the IRB from moving forward. The Bureau of Health Information will assist you to whatever degree it can, but until you specify the dimensions of the pilot and the sensitivity analysis, we won't know if that will require other assistance that goes beyond the internal limits. Mr. Chapin agrees that this is an appropriate investment of resources but cannot make a commitment to any amount. Mr. Chapin assured IRB members that there are internal resources which BHI can engage and he would look at the issue of investing further resources if necessary.

Dr. Gold asked members for suggestions as to what the next steps should be. Mr. Popowski stated that he would like to see Dr. Zimmerman draft up policies and criteria. Dr. Zimmerman told IRB members that he is pondering this and believes that he would end up using a concrete example, that it will be inductive in the sense that he will take a concrete example, try to work through it, and see what kinds of general insights are discovered. Dr. Zimmerman suggested engaging with individual members of the IRB, Dr. Millea in particular, to take an example, reasonably simple, and work through the whole process. Dr. Zimmerman suggested that he would work concurrently with BHI staff as well as staff from CHSRA to put this together. Dr. Gold asked if Dr. Zimmerman could put a document together for the next IRB meeting? Dr. Zimmerman stated that he would try to meet that deadline.

Discuss stakeholder issue(s)

Dr. Gold suggested that the IRB discuss the appropriate involvement of organizations and parties that might have an interest in the deliberations and process of this Board and what would be the best way of getting and maintaining the appropriate involvement. Dr. Gold asked how the Board of Health Care Information maintains involvement? Ms. Nugent stated the agendas for Board on Health Care Information meetings are distributed to a broad audience of people and as far in advance as possible. Internally, the Bureau of Health Information attempts to invite parties who may have an interest in a particular agenda item. Mr. Popowski also informed IRB members that e-mail is used frequently to communicate various matters to people. Dr. Gold asked if this is an item that calls for any decision by the IRB or is it something that we allow to simply evolve naturally. Dr. Zimmerman stated that he would like to see this evolve naturally since stakeholders are all politically sophisticated, knowledgeable and proactive on these issues. Mr. Popowski believes the IRB should keep its focus and not be too concerned about all the other external factors at this time. Dr. Gold suggested IRB members should encourage stakeholder participation whenever contact with them occurs. Ms. Nugent stated a broader group of stakeholders includes the data submitters, who are keeping an eye on this issue, and BHI is keeping them informed. Dr. Gold summarized the IRB will definitely keep the stakeholder issue in mind as the work of the IRB proceeds. Dr. Zimmerman suggested a parallel track for this issue and risk adjustment in terms of the procedures for taking on a request, deliberating about it, and making the decision about the request. Dr. Millea said there should be a standardized format for the request and then a deliberative process. Dr. Gold stated that perhaps there are comparable formats elsewhere that could be adapted. Ms. Nugent informed members that when a customized data request is received for hospital discharge patient-level data systems it evolves through a process of negotiation. If data submitters request customized data that focuses on an area that includes sensitive information, a negotiation occurs between the data requester and the researcher through a set of questions. BHI works to get the requester what they need without jeopardizing sensitive information or anything that would lead to patient identification.

Criteria for release of data (examining hospital data)

Mr. Miller distributed to the Board excerpts from a December 2000 BHI Workgroup report "Current

Practices for Protecting Non-Confidential Sensitive Information in Bureau of Health Information Data Systems." Sensitive information would include diagnosis, medical information, and procedures that were done. When BHI receives requests for individual records, the concern is that someone with access to a public use file may identify an individual through a combination of demographic or other characteristics and learn something new about that person. Requests for aggregate data present similar concerns, and cells in tables are examined. BHI employs several techniques to protect sensitive information including collapsing categories, aggregating time periods, and suppression methods. BHI requires customized data requests in writing and the requests are screened for appropriate uses. BHI also has the requester sign written agreements that detail what may or may not be done with the data, and how the requester is going to protect sensitive information. Mr. Miller stated with POV data, there would be different levels of analysis, and protection of physician identity and patient identity will be critical.

Dr. Gold asked, for the purposes of saving time, that members be prepared to discuss this topic at the next IRB meeting.

Meeting schedule

Dr. Gold noted that Dr. Zimmerman has learned of a schedule conflict and would request the March 21, 2003 meeting be changed to March 28, 2003. All IRB members agreed to the schedule change.

Items for upcoming Board meeting

- POV data collection project update
- POV Data Quality Report update
- Risk adjustment strategies
- Criteria for release of data
- Procedure for receiving requests (form or checklist)
- Deliberative procedure

Next Board meeting

The next Board meeting is scheduled for Friday, March 28, 2003, 10:00 a.m. to 12:00 p.m. at the State Office Building, 1 West Wilson Street, Conference Room 372, Madison, Wisconsin.

Adjournment

Dr. Gold adjourned the meeting at 11:58 a.m.